Title

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Journal

Violence against women, 23(13)

ISSN

1077-8012

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Publication Date

2017-11-01

DOI

10.1177/1077801216663657

Peer reviewed

Activist/Advocate Note

Violence Against Women
2017, Vol. 23(13) 1656–1668

DOI: 10.1177/1077801216663657
journals.sagepub.com/home/vaw
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Addressing Intimate Partner Violence Among Female Clients Accessing HIV Testing and Counseling Services: Pilot Testing Tools in Rakai, Uganda

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Abstract

The World Health Organization recommends that HIV counseling and testing (HCT) programs implement strategies to address how intimate partner violence (IPV) influences women's ability to protect themselves from and seek care and treatment for HIV infection. We discuss the process used to adapt a screening and brief intervention (SBI) for female clients of HCT services in Rakai, Uganda—a setting with high prevalence of both HIV and IPV. By outlining our collaborative process for adapting and implementing the SBI in Rakai and training counselors for its use, we hope other HCT programs will consider replicating the approach in their settings.

Keywords

HIV testing and counseling, intimate partner violence, Uganda

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Background

There is an expanding body of literature that demonstrates an association between HIV and intimate partner violence (IPV) among women. IPV and fear of IPV may increase a woman's risk of HIV infection by limiting her ability to adopt HIV-preventive behaviors such as condom negotiation and consistent condom use (see, for example, Dunkle & Decker, 2013; Hatcher et al., 2014). Also, HIV status and disclosure may increase a woman's risk of subsequent IPV, and fear of violence can prevent women from getting their own results, sharing them with intimate partners, and/or accessing treatment (see, for example, Hatcher et al., 2012; Malaju & Alene, 2013; Maman, Mbwambo, Hogan, Kilonzo, & Sweat, 2001; Rujumba et al., 2012). The World Health Organization (WHO) recommends that HIV counseling and testing (HCT) programs implement strategies to address the way in which violence and fear of violence influence women's ability to protect themselves from and seek care and treatment for HIV infection (WHO, 2006). In January 2006, the WHO held a consultation to review promising strategies to support women who may fear or experience IPV as a consequence of HIV testing and/or HIV sero-status disclosure. Two of the key recommendations developed to guide programs and policies related to HCT were to address violence as a barrier: (a) to HIV disclosure and as an outcome of disclosure for some women and (b) to women implementing risk reduction strategies (WHO, 2006).

In response to the WHO recommendations, we implemented a screening and brief intervention (SBI) to promote safe HIV disclosure and risk reduction among women seeking HCT services in the rural Rakai District of Uganda. Rakai provided an appropriate setting for piloting these protocols given that IPV has been shown to be associated with HIV infection in Rakai (Kouyoumdjian et al., 2013) and the protocols could be integrated into an existing project. This SBI was conducted as part of a larger IPV and HIV prevention intervention called the Safe Homes and Respect for Everyone (SHARE) Project, which has been described in detail elsewhere (Wagman et al., 2016; Wagman et al., 2012). Exposure to SHARE was associated with significant reductions in physical and sexual IPV against women and overall HIV incidence, possibly as a result of significant increases in men's and women's disclosure of HIV results (Wagman et al., 2015). In this article, we describe the process followed to pilot the SBI tools. Our aim is to provide a more detailed description of adapting these tools in Rakai, so that HIV researchers and programmers can follow and adapt counseling tools to address IPV in their settings.

The Setting

This pilot project was conducted within the Rakai Health Sciences Program (RHSP), an HIV and reproductive health research and services delivery organization that began in 1988 and operates in approximately 50 communities that have been aggregated into 11 regions throughout the Rakai district. Rakai is a patriarchal society (Ellis, Manuel, & Blackden, 2011) with a generalized HIV epidemic with high HIV prevalence (12%) and HIV incidence (1.2 per 100 person-years; Grabowski et al., 2014), and high rates of IPV against women (29% in the past year; Kouyoumdjian et al., 2013). The core of

RHSP activities is the Rakai Community Cohort Study (RCCS), an open, community-based study that is described elsewhere (Wawer et al., 1998). The RHSP HIV counselors had undergone extensive training on providing HCT services, resided in the communities they served, and were accustomed to completing forms and documentation because the HCT program was offered in the context of a larger research study (Matovu, Kigozi, Nalugoda, Wabwire-Mangen, & Gray, 2002). RHSP counselors offered post-test counseling sessions to help clients assess and plan how to reduce their risks for HIV infection and/or transmission. These sessions were structured by the use of a checklist with priority issues; however, when SHARE was launched, the checklist did not include recommendations for assessing one's risk of disclosure-related violence or for negotiating safe sex in the context of an abusive relationship.

The Process

HCT Tools Addressing IPV for Use in Rakai

The project was a collaborative effort between University of North Carolina at Chapel Hill (UNC)-affiliated researchers, the SHARE staff, and the RHSP Counseling Department. Between April and July 2006, we followed recommendations put forth at the WHO Consultation and developed protocols for RHSP's HIV counselors to address experience or risk of IPV as it occurred in the lives of their female clients (WHO, 2006). Specifically, we piloted two tools to address IPV as a barrier to HIV disclosure (Tool 1) and as a barrier to women's implementation of risk reduction strategies (Tool 2). The goal of the pilot test was to adapt these tools for more widespread use in Rakai as part of the SHARE Project.

Tool 1: Addressing violence during counseling on HIV status disclosure. The first tool, originally developed in Tanzania, was used to enable counselors to address potential violence related to HIV-positive status disclosure (WHO, 2006). Counselors asked five questions that assessed a woman's risk of IPV from disclosing her HIV-positive serostatus to her male partner. Based on the client's answers, the counselor conducted an in-depth exploration of her domestic situation and potential negative outcomes as a result of disclosure to her male partner. Depending on this discussion, the counselor could then recommend a plan for the client to disclose to her partner at that time or provide alternative options of disclosure (see Figure 1).

Tool 2: Focusing on violence in risk reduction counseling during post-test counseling sessions. The second tool, originally developed for use with young people in Kenya, incorporated a focus on violence in post-test risk reduction counseling sessions (Family Health International and YouthNet, 2005). This tool consisted of role-play scenarios to facilitate discussion about condom use and prevention of sexual coercion, develop the client's skills, and allow her to practice what to say if her partner is pressuring her to have sex against her will or to have sex without a condom. There are separate sections with scenarios designed specifically for unmarried couples and

Disclosure Assessment: Counselors were trained to ask female clients the following questions:

1. Is your partner aware that you will be tested for HIV and will be receiving your test results? (Yes/No)
2. If you told your partner you tested positive for HIV do you think he would react supportively? (Yes/No)
3. Are you afraid of how your partner will react if you share your HIV test results with him? (Yes/No)
4. Has your partner ever physically hurt you? (Yes/No)
5. Do you think that your partner may physically hurt you if you tell him that you have tested for HIV and your HIV test results are positive? (Yes/No)

HIV disclosure recommended: Counselors were trained to encourage women to disclose their HIV status if they answered: (1) "Yes" or "No" to question 1, and (2) "Yes" to question 2, and (3) "No" to questions 3-5.

Alternative models of HIV disclosure: Counselors were trained to explore alternative options for disclosure if a woman answered: (1) "No" to question 2, and (2) "Yes" to any of the following questions, 3-5. Alternative options for disclosure included:

- Opting not to disclose
- Deferring disclosure to a time when the woman's safety could be insured
- Developing a plan for mediated disclosure in which the woman either brings her partner to the clinic to disclose in the presence of a counselor or identifies a trusted family member or friend who can be present with the woman when she shares her HIV test results with her partner.

Figure 1. Tool 1: Assessing risk of violence related to positive HIV disclosure to male partner.

others designed specifically for married couples. Figure 2 is the adapted version of the risk reduction tool that was used in the SHARE Project.

Before piloting, we refined the two tools for use in Rakai based on feedback the counselors provided about their extensive practical experiences in the field. First, the counselors confirmed that fear of IPV dissuaded many women from disclosing their HIV-positive status to their male partners. Second, counselors described scenarios they had observed to be barriers for uptake in risk reduction strategies among their female clients. This increased our understanding of the role that IPV played in relationships among couples in Rakai and helped us tailor the tools for our setting. We visited the local sites where HCT and SHARE activities were offered to better observe the context and issues that women in Rakai dealt with in regard to IPV and HIV testing. The tools were refined and translated into Luganda so they could be used in the region. Finally, we circulated the tools to RHSP management for commentary and approval for piloting in the field.

Counselor Training

A UNC-affiliated researcher and two SHARE team members trained counselors on the rationale and protocol for use of the tools. Twelve RHSP (seven male and five female)

Counselors were trained to introduce the risk reduction activity to clients: Condom use can effectively prevent the transmission of HIV between sexual partners. However, sometimes partners do not want to use condoms. Also, sometimes partners become violent when their partners ask them to use a condom or refuse to have sex. Therefore, it is important to develop skills to discuss condom use and the right not to have sex if you are not comfortable. We can go through some role playing that is intended to help you think about how your partner might react to using a condom and how you might respond.

ROLE-PLAY SCENARIOS TO ADDRESS THE RISK OF VIOLENCE

(For women in relationships)

If her partner says…	*She can say…*
"If you don't have sex with me without a condom, I will force you."	"A respectable man cannot force his partner into sex. I respect you and you ought to respect me. Let's talk about this calmly."
"I have a right to have sex with you without a condom. "	"I will have sex with you but I would prefer to use a condom, until we get tested. We need to protect our health."
"I paid a bride price for you. You have to have sex with me."	"Yes, you did pay a bride price. Don't you want to keep me healthy and alive so I can take care of our children?"

ROLE-PLAY SCENARIOS TO TALK ABOUT CONDOMS

(For younger couples and those in a relationship but not yet married)

If her partner says…	*She can say…*
"We have never used a condom before."	"I don't want to take any more risks for HIV and STIs."
"Don't you trust me?"	"I trust you are telling the truth but with some STIs there are no symptoms. Let's be safe and use condoms."
"It seems you have another boyfriend."	"I am very faithful to you but we need to protect ourselves from HIV"

(For married/permanent couples)

If her partner says…	*She can say…*
"But we want to have more children."	"But we need children who are planned and healthy. We need to protect our health by wearing condoms."
"I thought you said condoms were for casual partners?"	"I also thought so but we need to face the facts. I want us to stay happy and healthy."
"You have HIV, not AIDS. We do not need to use a condom!"	"Even if you do not have AIDS, HIV can be passed from me to you. If you prevent HIV, you prevent AIDS."

Figure 2. Tool 2: Risk reduction counseling for women at risk of IPV.
Note. IPV = intimate partner violence.

counselors attended a 2-day training at the RHSP headquarters in Kalisizo, Rakai. Given that the counselors had already been trained extensively on providing HIV test results and counseling clients, the workshop focused on integrating the SBI into their existing counseling responsibilities.

After an overview of the agenda and introductions, a didactic session was held on the associations between IPV and HIV found in the scientific literature and the need for addressing these issues in Rakai. Next, counselors were introduced to the purpose of the pilot, the two counseling tools, and the role they would have in implementing the pilot intervention. The counselors learned about client eligibility and in which circumstances each of the tools was designed to be used. The three-member training team went over the two forms that counselors were to complete after each session and notified them that they would be visiting their sites and conducting follow-up interviews at the end of the pilot period. The two SHARE team members took turns giving a more in-depth review of each of the tools, and conducted a question and answer session to ensure that counselors understood the purpose of the tools and when to use them. At the end of the first day, the counselors worked in small groups to generate additional scenarios based on their own experiences providing HCT to women.

On the second day, counselors engaged in role-play activities to become more comfortable with the counseling tools. The role-play activity for the first tool was introduced and counselors divided into pairs to practice the scenarios. Some counselors then volunteered to present their role-plays to the larger audience. The same process was repeated for the second tool. The training ended with a review of expectations for the counselors over the pilot period and scheduling site visits and follow-up interviews.

Pilot Testing the Tools

Six counselors (four female and two male) were selected for participation in the pilot: one counselor from each of the four regions where the SHARE intervention operated and two from the RHSP headquarters. The counselors piloted the tools over a 3-week period. The counselors were asked to use each tool with at least five clients (total of 10 clients) based on established eligibility criteria. The disclosure tool was used with female clients: (a) living with her partner for at least 6 months, (b) receiving her HIV test results for the first time, and (c) testing positive for HIV or indicating that testing for HIV (regardless of sero-status) could cause a violent reaction from her male partner. The risk reduction counseling tool was used with female clients, regardless of her HIV sero-status: (a) who reported that her male partner was violent toward her in the past year and/or (b) whose male partner would not get tested for HIV.

During the pilot, the research team held frequent check-ins with the counselors to address any questions and concerns about the tools. After each session, counselors were asked to complete a summary sheet to document their experiences. Counselors were invited to use these notes to reflect on their experiences during the follow-up interview. The research team conducted observations to gain a better understanding of the settings, the flow of clients coming in for testing, and to witness the implementation of tools and reactions of clients.

At the end of the pilot period, the UNC-affiliated researcher conducted individual interviews with each of the six counselors who participated in the pilot phase. The goal of these interviews was to better understand the perceived feasibility and acceptability of the counseling tools. The counselors shared their perspectives on what worked well in implementing the counseling tools, some of the challenges to using the tools, how clients received the tools, and recommendations for further refining of the tools. The interviews, lasting 45-60 min, were conducted in English in the privacy of counselors' offices.

The pilot phase protocol, interview guides, and consent forms were approved by the Uganda Virus Research Institute's Science and Ethics Committee, the Uganda National Council of Science and Technology, and the institutional review board (IRB) at UNC. All counselors provided consent to be interviewed and observed. They were assured that participation was voluntary and that responses would not be linked directly to any specific person.

The UNC-affiliated researcher reviewed the information from the interviews. She read through notes from the interviews to identify the positive and negative aspects of the two tools as experienced by counselors during the pilot phase. She noted preliminary conclusions based on the interviews and presented them back to the counselors as a group. Counselors attended a feedback meeting to discuss the pilot period, to make recommendations on further adaptation, and to plan for future implementation of protocols. After collecting all the interviews and observation notes, the information was coalesced to assess the acceptability of the tools and the feasibility of implementing this intervention into the counseling protocol of RHSP. The research team classified areas of acceptability as to how well counselors believed that the tools helped them to ask their female clients about IPV, to discuss how violence and the fear of violence influences the decision to disclose an HIV-positive sero-status, and to work with their female clients to practice role-play activities to negotiate risk reduction strategies with their male partners. Acceptability was also determined by how well female clients of the HCT services responded to counselors bringing up the issue of IPV. The team classified areas of feasibility as how likely counselors would be able to integrate these tools into their normal HCT sessions, what accommodations or changes would need to be made, and the likelihood of future use and/or standardization of including the two counseling tools into HCT sessions at RHSP. The results were also presented to the RHSP management team and scientists.

Benefits of the Counseling Tools

Overall, the use of the tools was well received by the counselors. They reported that both tools were easily integrated into the post-test counseling sessions. In most instances, using a tool did not add extensive time to the counseling session. On average, it took between 5 and 10 min to go through one of the tools, which was not a major barrier for the RHSP counselors. The counselors said that asking the questions felt natural and the conversations that ensued flowed well. One counselor explained that "it was good to have a *guide* to discuss the disclosure." Another counselor noted

that "It (Tool 1) was easy. It was even easy for the clients, for these women, to talk about it, because they lacked this information about how to go about this issue of disclosure." The counselors also explained that it was easy to bring up the discussions about condom use and risk reduction with their female clients as part of the risk reduction tool. Both male and female counselors reported similar ease and comfort using these counseling tools.

All counselors said the tools facilitated their ability to address violence in HCT sessions by allowing them to raise issues related to IPV and fear of IPV with their female clients. As one counselor explained, "Protocol one is just the key opener for someone to tell you what is happening. These questions were so good that it makes someone open up." Comments such as "the tools were helpful and the tool [risk reduction tool] will empower them" were shared by the counselors. When clients expressed fear that they would be abused after disclosing their HIV-positive results, the tools were particularly relevant to the counselors' job. One counselor said "the women want to disclose, but they are afraid what will happen, what the husband will do." Counselors also reported that the tools guided them to successfully probe deeper about IPV and how the HIV test results may increase a woman's risk of violence. The first tool was also instrumental in allowing counselors to further explore barriers to disclosure of HIV test results.

Challenges With Implementing the Counseling Tools

Counselors noted some instances where the tools were difficult to use or might not be effective with their clients. One example shared pertained to difficulty encountered when introducing the risk reduction tool with those clients who did not want to use condoms. Counselors mentioned that not all clients saw the benefits of using condoms. In Rakai, it is not culturally normative for married/partnered men and women to use condoms because pregnancy is implicit to marriage. In addition, "it was hard when the clients who were HIV negative to get them to see the benefits of using a condom." Counselors mentioned that they would first need to address the importance of condom use before moving to discussing condom negotiation skills. The counselors reported that although clients theoretically agreed that the scenarios were good, some expressed hesitation about being able to realistically make those statements to their male partners. The counselors suggested that for at least some clients, the role-playing and advice could not be a one-time session nor a complete intervention for all clients. Instead, they felt follow-up sessions with female clients would be instrumental for building confidence in using the risk reduction strategies with their male partners. "You sometimes need to have women come again and for follow-up." Another issue that emerged was the need to change our criteria for using tool 1 to address disclosure-related violence. We planned to have counselors pilot the tool only with women getting tested for the first time, but there were very few women who came to test for the first time during the pilot phase. Therefore, we piloted the tool with women regardless of how many times they had come for HCT services. There were benefits to using the tool with all women regardless of whether or not it was the first time testing. As one counselor explained, "there are some women who come again and they have not yet

disclosed, and they have the same problems." In the end, we concluded that both tools could be used with all women, regardless of whether it was their first time testing or whether they had previously received HCT services.

Recommendations

Several recommendations were made during the pilot period. One was the need to create more scenarios for role-play during the risk reduction counseling sessions, so counselors would have a larger set of examples to select from when counseling women. The counselors mentioned that they could share additional ideas for scenarios with each other as they got more experience using the tools and that "some clients provided more ideas for responses . . . they would say that this is how we can also respond" and these ideas could be written down and shared. A second recommendation was to consider that both these counseling tools may need to be repeated or spread out over multiple sessions with individual clients. Some female clients would benefit from repeat exposure to the risk reduction tool and it may take practice before women felt comfortable applying these strategies. One counselor noted that "women said that they would try . . . that it would be their first time to ask [partners about condom use]." Instances such as this highlight the need for following up. In addition, it may take more than one session for some clients to develop a disclosure plan. A third recommendation was to consider the development of similar counseling tools to facilitate the discussion about IPV with male clients of HCT. A fourth recommendation was to provide continued opportunities for the counselors to train on the implementation of the SBI. For example, one counselor explained, "I wish we would have more discussions after this training. That we share information about using the tools, and probably as a group how best to use them." The counselors who participated in the pilot agreed that the tools should be used within RHSP's standard HCT model and were enthusiastic about scaling up the SBI within the SHARE program.

Scaling Up for Use in the SHARE Intervention

Both SBI tools were refined and integrated into RHSP's standard HCT procedures for female clients in the four SHARE intervention regions. Refinements were made in response to lessons learned during this pilot study and included not limiting counseling sessions to one visit and using the role-play scenarios as a guide, not as a script. Some counselors felt the issues related to the client's experiences surrounding IPV warranted more than one session to effectively handle them. Therefore, counselors were encouraged to work with their clients to decide on how many visits they felt were useful. Furthermore, although the risk reduction scenarios were perceived by most clients as helpful, some felt they could not realistically be used with their partners because they did not seem appropriate or did not align with their personal experiences. As a result, we trained the counselors to develop personalized role-play content based on what each client felt would be most useful and comfortable in her own relationship (Wagman et al., 2016).

Conclusion

This article outlines the process for identifying counseling tools to address violence against women in HCT sessions, adapting these tools for the Rakai setting, having counselors pilot the tools, and conducting an assessment of the pilot. This pilot project showed that two HCT tools that address IPV related to disclosure and risk reduction could be successfully adapted for use in a rural Ugandan setting. The pilot phase also indicated that with proper training, both female and male counselors could easily integrate these tools in the standard counseling sessions for female clients in the RHSP. All counselors in this project had been trained to provide HIV counseling and discuss sensitive topics with both women and men. This may not be the case in all settings. It would be important to consider the cultural, gender, and social norms around the discussion of IPV, HIV, and associated risk factors when identifying and training counselors to implement these counseling tools. The counselors who participated in the pilot reported that these tools were beneficial in starting the conversation about IPV in women's relationships, the fear of violence from disclosure of an HIV-positive serostatus to male partners, and the role violence plays in women's ability to negotiate consensual sex and the use of condoms.

The findings from this pilot study add to the limited information available on intervention strategies to address IPV during HCT with women. Researchers found that HIV prevention strategies could feasibly be integrated into group-based IPV programs for women in South Africa (Sikkema et al., 2010). Another group of researchers concluded that screening for IPV as part of HCT sessions with lay counselors is acceptable to female clients of these services in South Africa; however, more work is needed to ensure that counselors are well equipped to discuss gender power inequalities and their influence on HIV risk (Christofides & Jewkes, 2010). A recent literature review found information on nine interventions to address IPV and HIV in sub-Saharan Africa, of which two were based in health care settings and the remaining seven were community based (Anderson, Campbell, & Farley, 2013). The authors concluded that there is a need for more thorough evaluation of these programs and that nurses and other clinic- and hospital-based practitioners providing HIV services could potentially be incorporated into screening and intervention programs for IPV (Anderson et al., 2013).

The conclusions drawn from this pilot project should be considered within their limitations. The tools were implemented with counselors who had been well trained, and RHSP already had an ongoing project (SHARE) to address violence against women in the Rakai community. The process for implementing the counseling tools may have been made smoother and faster than it would take in settings where this infrastructure does not already exist. Also, more extensive process evaluation methods would have provided qualitative and quantitative research data to strengthen the conclusions drawn from this pilot study. Another limitation of this pilot was that clients of HCT services were not interviewed by the research team. Acceptability and feasibility of the tools were only assessed from the experiences of counselors. Furthermore, in-depth research should be conducted to better understand women's perceptions of these two HCT tools.

The tools were successfully integrated into the communities where SHARE operated until 2009 and included in a regional guide for HCT counselors on how to discuss violence and HIV (Raising Voices, 2008). The tools may also be relevant for other settings, and the process of adaptation and piloting could be replicated throughout sub-Saharan Africa and elsewhere. Several lessons learned could be beneficial for replicating these tools in other communities. First, counselors should be provided training not only on how and when to use the tools, but must receive awareness training on the rationale for addressing IPV violence as part of the HCT sessions. Counselors need to be prepared for discussing IPV with their clients. Second, the community should be involved in developing appropriate scenarios for inclusion in the risk reduction tool. It is important that the female clients can relate to the scenarios presented and that the tools are adapted to be linguistically and culturally appropriate. Third, a pilot phase, such as the one presented in this article, is an effective way to start the adaptation and integration of these counseling tools before scaling up. And, fourth, the counseling tools should be incorporated into an existing HCT program so it can be more easily scaled up and sustained. By outlining our process for adapting, training, and assessing the counseling tools in this article, we hope that other HCT programs will consider opportunities to implement similar counseling tools.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The SHARE intervention was funded by the President's Emergency Plan for AIDS Relief (CoAg GH000817). EJK was supported by a travel award from the UNC Center for Global Initiatives.

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